

# C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

**DATE NOTICE SENT TO ALL PARTIES:** Jan/15/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 1 Surgery; Open reduction, internal fixation of the left ulna with possible grafting, as an outpatient.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Orthopedic Surgery Fellowship Trained Spine Surgery

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for 1 Surgery; Open reduction, internal fixation of the left ulna with possible grafting, as an outpatient has been established

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who was injured on XX/XX/XX when he sustained an open fracture the distal radius with a non-displaced fracture of the ulna. The patient required irrigation and debridement of the dorsal wounds of the distal radius with a fuller approach. A distal radial plate was placed during the procedure. The patient was followed following the initial open reduction and internal fixation procedure. The XX/XX/XX report noted some bridging callus of the ulna with good alignment of the radius. Some tenderness over the ulnar fracture site was evident. Patient was continued in the splint for an additional three weeks. The XX/XX/XX report noted that on radiographs the radius had clearly healed with possible healing of the ulna. The XX/XX/XX report strength at the XX/XX/XX report indicated that radiographs did not show clear lucency of the fracture site. The patient still had significant tenderness at the fracture area. It was felt that the patient had a non-union and required additional internal fixation with some grafting. The patient was seen for second opinion. The patient described tenderness to palpation on physical examination at the mid and distal third of the left ulna. XX reviewed the radiographs which show well healed for radius fracture. The ulna did not appear to be fully healed after six months. The XX/XX/XX report again recommended additional internal fixation of the ulnar fracture with bone grafting. The initial request for the procedures was denied on XX/XX/XX as there was no clear evidence of a non-union. The request was again denied on XX/XX/XX as there were no radiographs or CT imaging's imaging studies noting pathology.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The clinical records clearly indicate that the patient's radiographic studies of the left upper extremity were obtained in office. The patient has two evaluations, one from XX and a second opinion from XX that both opined that there is a lack of healing at the distal ulna most consistent with a non-union. Given that the patient has persistent tenderness at the fracture site more than six months after the initial injury, it is reasonable to ascertain that a non-union is present at the distal ulna, which

requires additional treatment. The proposed open reduction and internal fixation with bone grafting to address the non-union would be considered appropriate standard of care for guidelines. Therefore, it is this reviewer's opinion that medical necessity for 1 Surgery; Open reduction, internal fixation of the left ulna with possible grafting, as an outpatient has been established and the prior denials are overturned.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)